TUFTS Health Plan

## WELLNESS ALLOWANCE BENEFIT:

# How to Get Your $150 Reimbursement

**As a Tufts Medicare Preferred HMO plan member,** each calendar year you can get up to a total of $150 toward fees you pay for:

- **Fitness classes led by an instructor for yoga, Pilates, Tai Chi, and/or aerobics.**
- **Membership in a qualified health club or fitness facility.** A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment Examples include: YMCAs, Tufts Health Plan's network of fitness centers in Massachusetts; Curves®; & Fitness Together.
- **Nutritional counseling provided by a registered dietician or licensed nutritional counselor.**
- **Visits to a licensed acupuncturist.**
- **Participation in wellness programs such as:** certified instructor-led "Matter of Balance", chronic disease self-management, Diabetes workshop, Healthy Eating for Successful Living, Healthy IDEAs, Powerful Tools for Caregivers, Arthritis Foundation Exercise, Fit for Your Life, AAA Senior Driving and Enhance Wellness, such as memory fitness activities.

  Memory fitness programs eligible for reimbursement must meet the following criteria:
  1) The program must help you set a goal (e.g. a memory fitness goal)
  2) The program must track your progress towards your brain fitness goals
  3) The program must have a publication in a peer-reviewed journal supporting its effectiveness toward improving brain fitness

Please note, this benefit does not cover membership fees you pay to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers, country clubs, or for sports activities such as golf and tennis.

**To Get Your Reimbursement Send Us:**

- The completed form on the back of this page (Only one member request per form please).
- Photocopies of one of the following:
  - Dated, paid receipt with the name of the facility, class, or counselor preprinted on the receipt, and the amount paid
  - Front and back of cancelled check written to the facility, class, or counselor
  - Credit card statement or receipt identifying the facility, class, or counselor

Photocopies must be on 8.5" x 11" paper. Multiple receipts can be included on one page.

Mail the form, paid receipts or statements to:

**Tufts Health Plan Medicare Preferred**
**Wellness Benefit**
**P.O. Box 9183**
**Watertown, MA 02471-9183**

Please keep copies of all the paperwork you send us. We are not able to return photocopies of receipts or agreements, even if the request for payment is denied.

**Remember to check with your doctor before starting an exercise program!**

**For more information, call Customer Relations at 1-800-701-9000, (TTY 1-800-208-9562).** Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (From October 1 – February 14, representatives are available 7 days a week 8:00 a.m. – 8:00 p.m.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

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Tufts Health Plan is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan depends on contract renewal.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits may change on January 1 of each year.

This information is available for free in other languages. Please call our Customer Relations number at 1-800-701-9000 (TTY 1-800-208-9562), Monday - Friday 8 a.m. - 8 p.m. (from Oct. 1 - Feb. 14 representatives are available 7 days a week, 8:00 a.m. - 8:00 p.m.).

Esta información está disponible de forma gratuita en otros idiomas. Comuníquese con nuestro departamento de atención al cliente al número 1-800-701-9000 para obtener información adicional. (Los usuarios de TTY deben llamar al 1-800-208-9562). El horario es de lunes a viernes, de 8 am a 8 pm (del 1 de octubre al 14 de febrero, los representantes están disponibles los 7 días a la semana, de 8 am a 8 pm).

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# WELLNESS ALLOWANCE BENEFIT REIMBURSEMENT FORM

TUFTS Health Plan

**Please enter ALL information requested and print clearly. (One form per member.)**

## Your Information

Last Name: _____ First Name: _____ Middle Initial: ____

Gender: ☐ Male ☐ Female Date of Birth: ____ / ____ / _____ (M M / D D / Y Y Y Y) Phone Number: _____

Tufts Health Plan Medicare Preferred Member ID #: _____ Benefit Year: _____ (calendar year)

Street Address: _____

City: _____ State: _____ Zip Code: _____

## Facility, Class, Counselor, or Program Information

Facility/Class/Counselor/Program Name: _____

Facility/Class/Counselor/Program Address: _____

**I am requesting reimbursement for (check all boxes that apply):**

☐ Club/Facility Membership fee(s) ☐ Nutritional Counseling fee(s) ☐ Acupuncture ☐ Fitness class fee(s)
☐ Matter of Balance program ☐ Chronic disease self-management program
☐ Wellness Programs (specify) _____

If you are applying your benefit toward a health club or fitness facility, please confirm you received an orientation to the facility and equipment: ☐ Yes, I received an orientation

## How to Submit This Form (please allow 45 days for processing of completed form)

- You can submit this form with paid receipts once and receive your $150 Wellness reimbursement in full, OR you may submit this form with paid receipts several times until you have received up to $150.
- You can receive up to $150 per calendar year (January 1 – December 31).
- Submit photocopies of:
  - Dated & paid receipts
  - Completed & signed Wellness reimbursement form
- Total reimbursement you are requesting:
  ☐ $150.00
  ☐ Less than $150.00
  Indicate Amount $ _____
- **Please mail to:**
  Tufts Health Plan Medicare Preferred
  Wellness Benefit
  P.O. Box 9183
  Watertown, MA 02471-9183

**Reimbursement requests must be received by Tufts Health Plan Medicare Preferred by March 31st of the following year.**

## Authorization (this form must be signed and dated below)

I authorize the release of any information to Tufts Health Plan Medicare Preferred about my health club membership. I certify that the information provided is complete and correct and that I have not previously submitted for these services.

Member's Signature: _____ Date: _____